Group Vision Care Policy

Group Name: **THE CITY OF WICHITA**
Group Number: **12041964**
Effective Date: **JANUARY 1, 2006**

CERTIFICATE OF COVERAGE

Provided by:

VISION SERVICE PLAN INSURANCE COMPANY

3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

This form is a summary of the Policy provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Policy itself. A copy of the Policy will be furnished on request.

DEFINITIONS:

BENEFIT AUTHORIZATION	Authorization issued by VSP identifying the individual named as a Covered Person of VSP, and identifying those Plan Benefits to which a Covered Person is entitled.
COPAYMENTS	Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.
COVERED PERSON	An Enrollee or Eligible Dependent who meets VSP's eligibility criteria and on whose behalf Premiums have been paid to VSP, and who is covered under the Policy.
EMERGENCY CONDITION	A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.
ENROLLEE	An employee or member of Group who meets the eligibility criteria specified under section VI. ELIGIBILITY FOR COVERAGE of the Policy.
EXPERIMENTAL NATURE	Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.
GROUP	An employer or other entity which contracts with VSP for coverage under the Policy in order to provide vision care coverage to its Enrollees and their eligible dependents.
MEMBER DOCTOR	An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.
NON-MEMBER PROVIDER	Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.
PLAN BENEFITS	The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Policy, as defined on the enclosed insert or in the Schedule of Benefits attached as Exhibit A to the Group Policy document maintained by your Group Administrator.
PREMIUMS	The payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached as Exhibit B to the Group Policy document maintained by your Group Administrator.

RENEWAL DATE The date on which the Policy shall renew or terminate if proper notice is given.

SCHEDULE OF BENEFITS The document, attached as Exhibit A to the Group Policy maintained by your Group Administrator, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Policy.

SCHEDULE OF PREMIUMS The document, attached as Exhibit B to the Group Policy maintained by your Group Administrator, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.

USUAL AND CUSTOMARY The fee a Member Doctor normally accepts for providing vision services to private pay patients and those patients not covered by Medicare or Medicaid programs. Member Doctors complete fee surveys every six months reporting their usual and customary fees which assists VSP in determining the most frequently charged fees for comparable services within the same geographic area.

VISUALLY NECESSARY OR APPROPRIATE Services and materials medically or visually necessary to restore or maintain a patient's visual acuity and health and for which there is no less expensive professionally acceptable alternative.

ELIGIBILITY FOR COVERAGE

Enrollees: To be covered, a person must currently be an employee or member of the Group, and meet the established coverage criteria mutually agreed upon by Group and VSP.

Eligible Dependents: If dependent coverage is provided, the persons eligible shall include the legal spouse of any Enrollee, and any unmarried child of an Enrollee who has not reached the limiting age as shown on the enclosed insert, including any natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon the Enrollee for support and maintenance.

PREMIUMS

Your Group is responsible for payments of the periodic charges for your coverage. Your Group will notify you of your share of the charges, if any. The entire cost of the program is paid to VSP by your Group.

PROCEDURES FOR USING THE POLICY

1. When you want to receive Plan Benefits, contact VSP or a Member Doctor. A list of names, addresses, and phone numbers of Member Doctors in your area can be obtained from your Group, Plan Administrator, or VSP. If this list does not cover the area in which you wish to seek services, call or write the VSP office nearest you to find one that does.

2. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization directly to the Member Doctor. If you contact a Member Doctor directly, you must identify yourself as a VSP member so the doctor can obtain Benefit Authorization from VSP.

3. When such Benefit Authorization is provided by VSP, and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against the Policy in spite of your termination of coverage or the termination of the Policy. Should you receive services from a Member Doctor without such Benefit Authorization or obtain services from a Non-Member Doctor, you are responsible for payment in full to the provider.

4. You pay only the Copayment (if any) to a Member Doctor for services under this Policy. VSP will pay the Member Doctor directly according to its agreement with the doctor.

   Note: If you are eligible for and obtain Plan Benefits from a Non-Member Provider, you should pay the provider his/her full fee. You will be reimbursed by VSP in accordance with the Non-Member Provider reimbursement schedule shown on the enclosed insert, less any applicable Copayments.

5. In emergency conditions, when immediate vision care of a medical nature such as for bodily trauma or disease is necessary, Covered Person can obtain covered services by contacting a Member Doctor (or Out-of-Network Provider if the attached Schedule of Benefits indicates Covered Person's Plan includes such coverage). No prior approval from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Acute Eye Care and Primary Eye Care Plans. If coverage for one of these plans is not indicated on the attached Schedule of Benefits or Addendum, Covered Person is not covered by VSP for medical services and should contact a physician under Covered Person's medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP's Customer Service Department for assistance.

   Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments and exclusions stated herein. Reimbursement to Member Doctors will be made in accordance with their agreement with VSP.

6. In the event of termination of a Member Doctor's membership in VSP, VSP will be liable to the Member Doctor for services rendered to you at the time of termination and permit Member Doctor to continue to provide you with Plan Benefits until the services are completed or until VSP makes reasonable and appropriate arrangements for the provision of such services by another Member Doctor.

BENEFIT AUTHORIZATION PROCESS

VSP authorizes Plan Benefits according to the latest eligibility information furnished to VSP by Covered Person's Group and the level of coverage (i.e. service frequencies, covered materials, reimbursement amounts, limitations, and exclusions) purchased for Covered Person by Group under this Policy. When Covered Person requests services under this Policy, Covered Person's prior utilization of Plan Benefits will be reviewed by VSP to determine if Covered Person is eligible for new services based upon Covered Person's Policy's level of coverage. Please refer to the attached Schedule of Benefits for a summary of the level of coverage provided to Covered Person by Group.

Prior Authorization

Certain Plan Benefits require VSP's prior authorization before such Plan Benefits are covered. VSP's prior authorization determinations are based upon criteria developed by optometric and ophthalmic consultants and approved by VSP's Utilization Management Committee and Board of Directors.

A. **Initial Determination**: VSP will approve or deny requests for prior authorization of services within fifteen (15) calendar days of receipt of the request from the Covered Person's doctor. In the event that a prior authorization cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

B. **Appeals**: If VSP denies the doctor's request for prior authorization, the doctor, Covered Person or the Covered Person's authorized representative may request an appeal of the denial. Please refer to the section on Claim Appeals, below, for details on how to request an appeal. VSP shall provide the requestor with a final review determination within thirty (30) calendar days from the date the request is received. A second level appeal, and other remedies as described below, is also available. VSP shall resolve any second level appeal within thirty (30) calendar days. Covered Person may designate any person, including the provider, as Covered Person's authorized representative.

For more information regarding VSP's criteria for authorizing or denying Plan Benefits, please contact VSP's Customer Service Department.

BENEFITS AND COVERAGES

Through its Member Doctors, VSP provides Plan Benefits to Covered Persons as may be Visually Necessary or Appropriate, subject to the limitations, exclusions, and Copayment(s) described herein. When you wish to obtain Plan Benefits from a Member Doctor, you should contact the Member Doctor of your choice, identify yourself as a VSP member, and schedule an appointment. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization for you directly to the Member Doctor prior to your appointment.

IMPORTANT: The benefits described below are typical services and materials available under most VSP plans. However, the actual Plan Benefits provided to you by your Group may be different. Refer to the attached Schedule of Benefits and/or Disclosure to determine your specific Plan Benefits.

1. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated. Each Covered Person is entitled to a Eye Examination as indicated on the enclosed insert.

2. Lenses: The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses. Each Covered Person is entitled to new lenses as indicated on the enclosed insert.

3. Frames: The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency. Each Covered Person is entitled to new frames as indicated on the enclosed insert.

4. Contact lenses: Unless otherwise indicated on the enclosed insert, contact lenses are available under this Plan in lieu of all other lens and frame benefits described herein.

   When you obtain Visually Necessary contact lenses from a Member Doctor, professional fees and materials will be covered as indicated on the enclosed insert with prior authorization from VSP. Coverage for Visually Necessary contact lenses regardless of whether they are obtained from a Member Doctor or Non-Member Provider is subject to review and authorization from VSP's optometric consultants.

   If you select contact lenses for other than Visually Necessary circumstances, they will be considered Elective contact lenses. When Elective contact lenses are obtained from a Member Doctor, VSP will provide an allowance toward the cost of professional fees and materials. A 15% discount shall also be applied to the Member Doctor's usual and customary professional fees for contact lens evaluation and fitting. Contact lens materials are provided at the Member Doctor's usual and customary charges.

5. If you elect to receive vision care services from one of the Member Doctors, Plan Benefits are provided subject only to your payment of any applicable Copayment. If your Plan includes Non-Member Provider coverage and you choose to obtain Plan Benefits from a Non-Member Provider, you should pay the Non-Member Provider his full fee. VSP will reimburse you in accordance with the reimbursement schedule shown on the enclosed insert, less any applicable Copayment. THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR THE MATERIALS. Availability of services under the Non-Member Provider reimbursement schedule is subject to the same time limits and Copayments as those described for Member Doctor services. Services obtained from a Non-Member Provider are in lieu of obtaining services from a Member Doctor and count toward plan benefit frequencies.

6. Additional Discount: Each Covered Person shall be entitled to receive a 20% discount toward the purchase of additional complete pairs of prescription glasses (lenses, lens options, and frames) from a Member Doctor. Additional pairs means any complete pair of prescription glasses purchased beyond the benefit frequency allowed by your Plan, as indicated on the enclosed insert. Additionally, each Covered Person shall be entitled to receive a 15% discount off the Member Doctor's professional fees for contact lens evaluations and fittings. Contact lens materials are provided at the doctor's usual and customary charges. Discounts are applied to the Member Doctor's usual and customary fees for such services and are available within twelve (12) months of the covered eye examination from the Member Doctor who provided the covered eye examination.

7. Low Vision Services and Materials (applicable only if included in your Plan Benefits outlined on the enclosed insert): The Low Vision Benefit provides special aid for people who have acuity or visual field loss that cannot be corrected with regular lenses. If a Covered Person falls within this category, he or she will be entitled to professional services as well as ophthalmic materials including but not limited to supplemental testing, evaluations, visual training, low vision prescription services, plus optical and non-optical aids, subject to the frequency and benefit limitations as outlined on the enclosed insert. Consult your Member Doctor for details.

COPAYMENT

The benefits described herein are available to you subject only to your payment of any applicable Copayment(s) as described in this booklet and on the enclosed insert. ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

This vision service plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following options, the Plan will pay the basic cost of the allowed lenses, and you will be responsible for the options extra cost, unless it is defined as a Plan Benefit in the Schedule of Benefits attached as Exhibit A to the Group Policy maintained by your Group Administrator.

- Optional cosmetic processes.
- Cosmetic lenses.
- Laminated lenses.
- Certain limitations on low vision care.

NOT COVERED

There is no benefit under this plan for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.38 diopter power); or two pair of glasses in lieu of bifocals.

- Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available.

- Medical or surgical treatment of the eyes.

- Corrective vision treatment of an Experimental Nature.

- Costs for services and/or materials above Plan Benefit allowances indicated on the enclosed insert.

- Services/materials not indicated as covered Plan Benefits on the enclosed insert.

LIABILITY IN EVENT OF NON-PAYMENT

In the event VSP fails to pay the provider, you shall not be liable for any sums owed by VSP other than those not covered by the policy.

COMPLAINTS AND GRIEVANCES

If Covered Person ever has a question or problem, Covered Person's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a Covered Person, the Covered Person may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Covered Persons also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to the Covered Person to indicate VSP's expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

Claim Payments and Denials

A. Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

B. Request for Appeals: If a Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, Covered Person may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the Covered Person's name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Covered Person the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. Covered Person or Covered Person's authorized representative should submit all requests for appeals to:

VSP

Member Appeals

3333 Quality Drive

Rancho Cordova, CA 95670

(800) 877-7195

VSP's determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative.

If Covered Person disagrees with VSP's determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

When Covered Person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. Covered Person should contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA Section 502(a)(I)(B), Covered Person has the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

TERMINATION OF BENEFITS

Cancellation conditions of your vision care Policy are shown on the enclosed insert. Plan Benefits will cease on the date of cancellation of this Policy whether the cancellation is by your Group or by VSP due to non-payment of Premium. If you are receiving service as of the termination date of the Policy, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of the Policy.

INDIVIDUAL CONTINUATION OF BENEFITS

This program is available to groups of a minimum of ten (10) employees and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees who may desire to retain same.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an eligible Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent COBRA applies, VSP shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.

VISION SERVICE PLAN INSURANCE COMPANY

3333 Quality Drive
Rancho Cordova, CA 95670

MONTHLY PREMIUM: *YOUR GROUP IS RESPONSIBLE FOR PAYMENT TO VISION SERVICE PLAN OF THE PERIODIC CHARGES FOR YOUR COVERAGE. YOU WILL BE NOTIFIED OF YOUR SHARE OF THE CHARGES, IF ANY, BY YOUR GROUP.*

ELIGIBILITY: *ENROLLEES & ELIGIBLE DEPENDENTS: UNMARRIED DEPENDENT CHILDREN ARE COVERED TO AGE 19 OR TO AGE 23 IF FULL-TIME STUDENTS. THE WAITING PERIOD IS THE SAME AS YOUR OTHER HEALTH BENEFITS.*

PLAN AND SCHEDULE: ***ENHANCED PLAN B - ADULT***

EXAMINATION:	*ONCE EVERY 12 MONTHS*
LENSES:	*ONCE EVERY 12 MONTHS*
FRAMES:	*ONCE EVERY 24 MONTHS*

TERM, TERMINATION AND RENEWAL: *AFTER THE POLICY TERM, THIS POLICY WILL CONTINUE ON A MONTH TO MONTH BASIS OR UNTIL TERMINATED BY EITHER PARTY GIVING THE OTHER SIXTY (60) DAYS PRIOR WRITTEN NOTICE.*

TYPE OF ADMINISTRATION: *BENEFITS ARE FURNISHED UNDER A VISION CARE PLAN PURCHASED BY THE GROUP AND PROVIDED BY VISION SERVICE PLAN (VSP) UNDER WHICH VSP IS FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF CLAIMS.*

VSP'S ADDRESS IS: *VISION SERVICE PLAN*
3333 QUALITY DRIVE
RANCHO CORDOVA, CA 95670

SCHEDULE OF BENEFITS

GENERAL

This Schedule lists the vision care benefits to which Covered Persons of VSP are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services, as indicated by the reimbursement provisions below. Vision care benefits may be received from any licensed eye care provider, whether Member Doctors or Non-Member Providers.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated.

PLAN BENEFITS	***MEMBER DOCTOR BENEFIT***	***NON-MEMBER PROVIDER BENEFIT***
VISION CARE SERVICES		
Vision Examination	*Covered in Full**	*Up to $ 45.00**
VISION CARE MATERIALS		
Lenses		
Single Vision	*Covered in Full**	*Up to $ 45.00**
Bifocal	*Covered in Full**	*Up to $ 65.00**
Trifocal	*Covered in Full**	*Up to $ 85.00**
Lenticular	*Covered in Full**	*Up to $ 125.00**
Frames	*Covered up to Plan Allowance**	*Up to $ 47.00**
CONTACT LENSES		
Visually Necessary		
Professional Fees and Materials	*Covered in Full**	*Up to $ 210.00**
Elective		
Professional Fees and Materials	*Up to $ 150.00**	*Up to $ 150.00**
LENS OPTIONS		
Anti-reflective coating	*Covered in Full**	*Not covered*
Color coating	*Covered in Full**	*Not covered*
Mirror coating	*Covered in Full**	*Not covered*
Scratch coating	*Covered in Full**	*Not covered*
Blended lenses	*Covered in Full**	*Up to $ 65.00**
Oversize lenses	*Covered in Full**	*Not covered*
Progressive lenses	*Covered in Full**	*Up to $ 85.00**
Tinted/Photo chromic	*Covered in Full**	*Up to $ 5.00**
UV (Ultraviolet protection)	*Covered in Full**	*Not covered*

**Subject to Copayment, if any.*

***Additional discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.*

COPAYMENT
There shall be no Copayment for the examination. If materials (lenses and frames) are provided, there shall be a Copayment of $ 40.00 payable by the Covered Person to the Member Doctor at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

LOW VISION
Professional services, as necessary, for severe visual problems not corrected with regular lenses, including:

Supplemental Testing	*Covered in Full*	*Up to $125.00*
(includes evaluation, diagnosis and prescription of vision aids where indicated)		
Supplemental Aids	*75% of cost*	*75% of cost*

Maximum allowable for all Low Vision benefits of $1000.00 every two (2) years.

SAFETY EYECARE
The Safety Eyewear Program provides a vision examination and associated materials for eligible employees who require safety eyewear due to the nature of their work. For more information regarding this Additional Benefit, please see the Safety Eye care Addendum attached hereto.

THIS EVIDENCE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE VISION PLAN. THE VISION PLAN DOCUMENT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

Exhibit C

ADDITIONAL BENEFIT RIDER

SAFETY EYECARE PLAN

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. This Rider forms a part of the Policy or Certificate of Coverage to which it is attached.

COVERED PERSONS WHO MEET THE ELIGIBILITY REQUIREMENTS OUTLINED UNDER ARTICLE VI. OF THE GROUP VISION CARE POLICY AND WHO REQUIRE SAFETY EYEWEAR DUE TO THE NATURE OF THEIR WORK SHALL BE ELIGIBLE FOR THE SAFETY EYECARE PLAN.

ELIGIBILITY

The following are Covered Persons under this Policy.

- Enrollee.
  See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated:

COPAYMENT

The benefits herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered person. Plan Benefits received from Member Doctors and Out-of-Network Providers require Copayments. Covered Persons must also follow Benefit Authorization procedures.

There shall be no Copayment for the examination. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be a Copayment of $40.00 payable by the Covered Person to the Member Doctor or the Out-of-Network Provider at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

SAFETY EYECARE PLAN

PATIENT OPTIONS

This vision service plan is designed to cover visual needs rather than cosmetic materials. When a Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Cosmetic lenses.
- Lens laminations.
- Certain limitations on low vision care.

NOT COVERED

There are no benefits for professional services or materials connected with:

- Subnormal vision aids.
- Orthotics or vision training and any associated supplementary testing not specifically related to Safety Eye Care.
- Plano lenses.
- Two pair of glasses in lieu of bifocals.
- Contact lenses.
- Replacement of lenses and frames furnished under this Policy that are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Examinations above a Limited Level unless the Covered Person: (i) is not eligible for an eye examination under the Plan to which this Rider is attached; (ii) received an eye examination from another Member Doctor during the same eligibility period; or (iii) received an eye examination during the preceding 6 months from a practitioner in the same Member Doctor's office that will be providing the Safety Eye Care examination.
- Rimless frames.
- Services and/or materials not indicated on this Rider as covered Plan Benefits.